

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-028597

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4010

FILED AUG 6 1963

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>BUCHANAN</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		c. CITY OR TOWN <b>ST. JOSEPH</b>	
Length of stay in 1b <b>5 days</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>V A HOSPITAL</b>		d. STREET ADDRESS (If outside, give location) <b>2716 JACKSON</b>	
3. NAME OF DECEASED (Type or print) First <b>EARL</b> Middle <b>DOUGLAS</b> Last <b>REYNOLDS</b>		4. DATE OF DEATH Month <b>July</b> Day <b>15</b> Year <b>1963</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1-22-97</b>
9. AGE (last birthday) <b>66</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Frank Reynolds</b>		13b. MOTHER'S MAIDEN NAME <b>Frances Hall</b>	
14. NAME OF HUSBAND OR WIFE <b>Astrid Reynolds</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WWI</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>VA Hospital Official Records, K.C. Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive and atherosclerotic heart disease with myocardial insufficiency</b> DUE TO (b) <b>Pulmonary infarcts, recent</b> DUE TO (c) <b>Multiple gastric and colonic ulcers</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour <b>4:30</b> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> Month, Day, Year <b>July 10, 1963</b>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION <b>St. Joseph, Mo.</b>		COUNTY <b>BUCHANAN</b> STATE <b>MISSOURI</b>	
21. VA attended the deceased from <b>July 10, 1963</b> to <b>July 15, 1963</b> Death occurred <b>4:30</b> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <b>S. H. CHOY, M.D.</b>	
22b. ADDRESS <b>VA Hospital, Kansas City, Mo.</b>		22c. DATE SIGNED <b>7-15-63</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7-15-63</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>		23d. LOCATION (City, town, or county) <b>St. Joseph, Mo.</b>	
24. FUNERAL DIRECTOR <b>Freeman Mortuary</b>		25. DATE RECD. BY LOCAL REG. <b>7-16-63</b>	
ADDRESS <b>Kansas City, Mo.</b>		26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>	

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

VS 300  
Rev. 4/59  
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AUG 8 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*J. P. Freeman*

Licensed Embalmer No. 2939

P.O. Address 5040

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.